Patient Care Quality Review Boards

Annual Report
2009/10

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Letter to the Minister of Health Services

June 2010

The Honourable Kevin Falcon
Minister of Health Services
Room 337, Parliament Buildings
Victoria, BC V8V 1X4

Dear Minister:

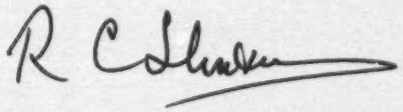
It is our pleasure to present the Patient Care Quality Review Boards' annual report for the period April 1, 2009 to March 31, 2010. This report has been prepared in accordance with sections 15(1) and 16(1) of the *Patient Care Quality Review Board Act*.

On behalf of the Patient Care Quality Review Board members, we would like to thank our staff for their invaluable support, and to acknowledge the dedication and tireless efforts of all those working to resolve patient care quality complaints in British Columbia. We would also like to express our gratitude to the patients, clients, residents and family members who allowed their voices to become a catalyst for care quality improvement.

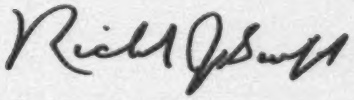
Respectfully submitted,

Dr. John H. Chritchley
Chair, Fraser / Vancouver Coastal / Provincial Health Services Patient Care Quality Review Boards

William Norton
Chair, Northern Patient Care Quality Review Board



Roger Sharman
Chair, Interior Patient Care Quality Review Board



Richard J. Swift, Q.C.
Chair, Vancouver Island Patient Care Quality Review Board

Introduction

B.C.'s Care Quality Complaints Process

In May 2008, government introduced the *Patient Care Quality Review Board Act*, which established a clear, consistent, timely and transparent patient complaints process in British Columbia.

Each health authority was required to establish a central Patient Care Quality Office (PCQO) to receive and respond to patient complaints.

The Act also established six Patient Care Quality Review Boards (the Boards) – one aligned with each of the regional health authorities, and one with the Provincial Health Services Authority. Independent from the health authorities and accountable to the Minister of Health Services, the Boards review patient care quality complaints that have first been addressed, but not resolved, by a health authority's Patient Care Quality Office.

After completing a review, the Boards may make recommendations to the health authority and/or the Minister of Health Services for care quality improvement and to improve the quality of the complaints process itself.

Local level complaints resolution
Best practices show patient complaints are best addressed and resolved at the time and place they occur.
Patient Care Quality Offices
Each health authority has a central Patient Care Quality Office. If patients are unable to resolve their complaints at the time of service, or wish to make a formal complaint, they can contact the Patient Care Quality Office in their region (see Further Information, p.39).
Patient Care Quality Review Boards
If patients are not satisfied with the response from the Patient Care Quality Office, or with how their complaint was handled, they can request a review by an independent Patient Care Quality Review Board.

About the Boards

Mandate

The Patient Care Quality Review Boards (the Boards) have four main activities, as set out in the *Patient Care Quality Review Board Act*:

- Receiving and reviewing patient care quality complaints;
- Reviewing any situation or matter at the direction of the Minister of Health Services;
- Making recommendations to the health authority and/or the Minister of Health Services, including recommendations to improve the process by which complaints are made and addressed, to improve the quality of patient care, to resolve a specific care quality complaint, or to address any other matter in a review requested by the Minister of Health Services;
- Monitoring, tracking and reporting on care quality complaints in British Columbia.

Review Process

Patients may request a review by submitting a review request form (by mail, email or fax), or by calling 1-866-952-2448. If the complaint is within a Board's jurisdiction, the health authority Patient Care Quality Office (PCQO) will be notified that a review is being conducted and asked to provide a copy of any information relating to the complaint.

The Board will review the facts and other background information, seeking expert advice and/or clarification from the health authority and complainant as required. The Board is expected to complete its review within a maximum of 120 business days.

Once the review is complete, the Board will send the complainant and the health authority a final decision letter, indicating whether any recommendations have been made. (A copy of these letters is also sent to the Minister of Health Services so that the Ministry can follow up with the health authority on the implementation of those recommendations.)

When recommendations have been made, the health authority will contact the complainant to discuss the outcome of the review and any actions that may be taken to address the care quality issues highlighted by the Board.

Jurisdiction

In general, the Boards may review any care quality complaint regarding services funded or provided by a health authority, either directly or through a contracted agency. The Boards may also review complaints regarding services expected, but not delivered, by a health authority (for example, a complaint regarding a cancelled surgery).

The Boards may only review complaints that have first been addressed by a health authority's Patient Care Quality Office (PCQO), unless directed otherwise by the Minister of Health Services.

The scope of activities and the jurisdiction of the Boards are established by the *Patient Care Quality Review Board Act* and the External Complaint Regulation.

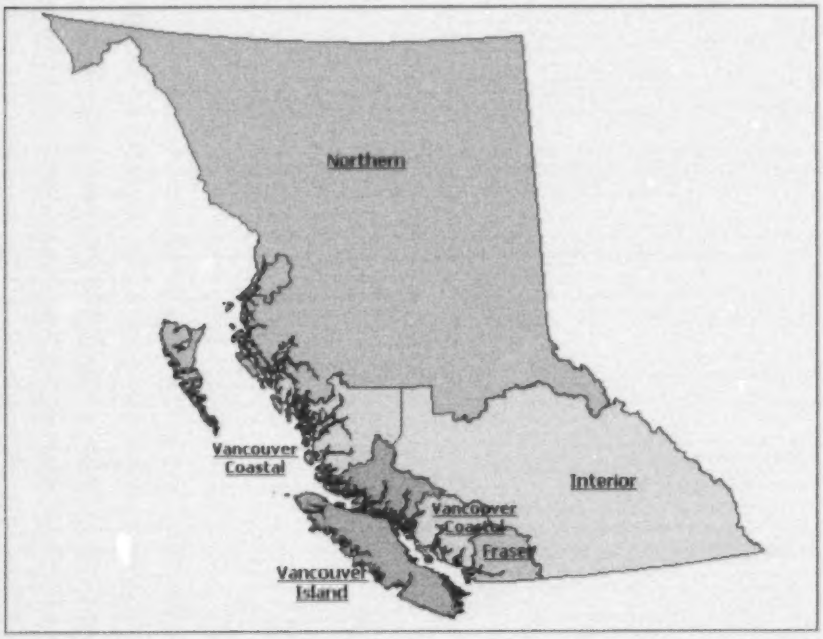
If a review request is not within the Boards' jurisdiction, the complainant will be redirected to the PCQO or to another body, as appropriate.

Current Members

Patient Care Quality Review Board members are appointed by the Minister of Health Services based on their expertise and experience. Members are eligible to serve terms of not more than two years, and may be reappointed to consecutive terms at the discretion of the Minister. Current health authority employees, board members and contractors are not eligible to serve on the Boards.

The Boards would like to acknowledge the contribution of former Board members Dr. Anthony Kenyon (Northern) and Dr. Gur Singh (Interior) in 2009/10.

Map of B.C.'s Health Authorities



Northern Patient Care Quality Review Board

William Norton, Chair

Lorna Dittmar
David Wilbur

Interior Patient Care Quality Review Board

Roger Sharman, Chair

Dr. Randall Fairey
Thomas Humphries
Gloria Morgan

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., Chair

Graham Alce
Jennifer A. English
Michael F. Patterson
Dr. Linda J.A. Thomson

Fraser / Vancouver Coastal / Provincial Health Services Patient Care Quality Review Board

Dr. John (Jack) H. Chritchley, Chair

Dr. John H. V. Gilbert
Robert D. Holmes
Sandra Wilking
Dr. Naznin Virji-Babul
Janis A. Volker

Achievements

2009/10 was a year of firsts for the Patient Care Quality Review Boards (the Boards). Most importantly, it was our first year of operation – and the first year patients had access to a clear mechanism for reviewing complaints that had not been resolved to their satisfaction at the health authority level.

The Boards celebrated our first anniversary in October 2009, and in February 2010, reached our first milestone – completing our 50th review.

Acknowledging this milestone by letter, the Minister of Health Services (the Minister) noted the Boards' achievement in enabling individual patient concerns to generate care quality improvements at both the health authority and health system level.

Indeed, in 2009/10, the Boards made 104 recommendations for quality improvement – resulting in new and amended policies and protocols, better communication tools for providers and patients, new education and training for staff, standardized procedures, enhanced compliance with policy and professional practice standards, lessons discussed and shared across the health authority, and more. (See a list of recommendations and a summary of responses, beginning page 10.)

"Already, our Board has seen a remarkable improvement in how the health authority communicates with patients throughout the complaints process, which helps to restore the patient's trust and confidence in the health care system – a key benefit of the program."

– Dr. John H. Chritchley
Board Chair

"A job well done."

– Complainant

2009/10 was also the first year that data regarding care quality complaints were consistently tracked and reported across the province (see Statistical Overview, page 7). Through the health authority Patient Care Quality Offices, the Boards collect data regarding the number and types of complaints received, the timeliness of service, and other related information and present this to the Minister quarterly and annually as a provincial picture of patient care quality complaints.

The 2009/10 data in this annual report will become the baseline against which the health authorities, the Boards and the Minister can begin to monitor the changing volume and nature of patient complaints over time. This information can improve the transparency and accountability of the health care system.

Finally, throughout our first year of operation, the Boards contributed to the culture shift taking place in complaints management across British Columbia. Already, the Boards have seen a growing awareness that patient complaints represent a unique opportunity for the health care system and should be discussed openly, without fear of blame or punishment. As a direct reflection of the patient experience, complaints allow health care providers and the health care system to learn and improve, to understand the issues from the patient's perspective and take action to address them before problems occur, or reoccur.

"...your work to date demonstrates careful analysis and thoughtful consideration of the patient experience."

– Honourable Kevin Falcon
Minister of Health Services

By giving an independent ear to the patient voice, the Boards are helping to drive that culture shift, to improve the quality of care, and to enhance patient trust in the public health care system.

Statistical Overview

Volume – Health Authority Patient Care Quality Offices

The Patient Care Quality Review Boards (the Boards) collect data from the health authority Patient Care Quality Offices (PCQOs) regarding the number and type of complaints received by the PCQOs in each quarter throughout the fiscal year. In 2009/10, there were 5,824 care quality complaints, 309 external complaints and 1,390 inquiries in British Columbia (see Appendix B for detail).[1] Of those 5,824 care quality complaints, only one per cent proceeded to the Boards for review – suggesting that the vast majority of complaints are resolved at the health authority level.

The table below presents the volume of care quality complaints received by each PCQO between April 1, 2009 and March 31, 2010.

Volume of Care Quality Complaints, by Health Authority and B.C., 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	2009/10 Total
Fraser Health Authority	532	553	495	577	**2,157**
Interior Health Authority	160	209	215	244	**828**
Vancouver Coastal Health Authority	214	217	202	221	**854**
Vancouver Island Health Authority	431	517	412	259	**1,619**
Northern Health Authority	27	42	57	62	**188**
Provincial Health Services Authority	63	37	36	42	**178**
British Columbia	1,427	1,575	1,417	1,405	**5,824**

Volume – Patient Care Quality Review Boards

The Boards may only review complaints that have first been addressed by the health authority's PCQO, unless otherwise directed by the Minister of Health Services. In 2009/10, the Boards accepted 65 review requests, completed 53 reviews, and cancelled two reviews at the request of the complainant.

In 43 of the completed reviews (81.0%), the Boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 10 of the completed reviews (19.0%), the Boards did not make recommendations, having found, for example, that the care provided had been good or that the circumstances of the complaint did not present an opportunity for care quality improvement. (See table next page for an overview of the Boards' volume by health authority.)

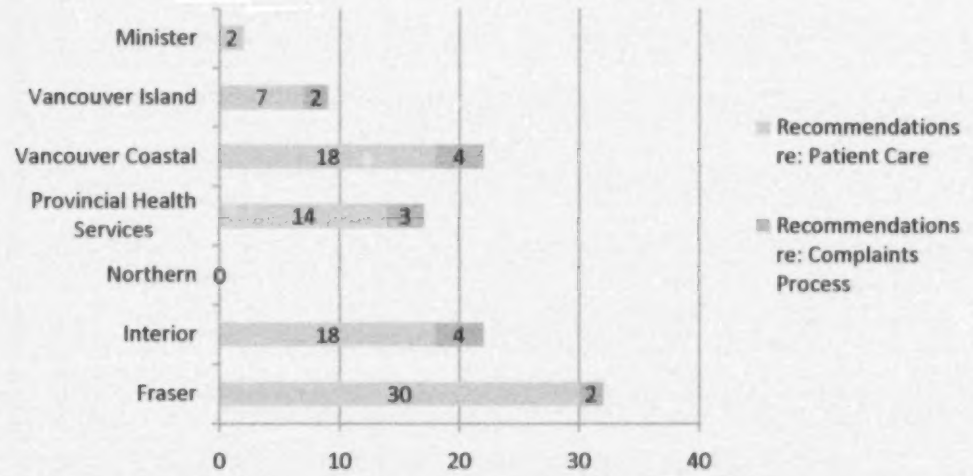
[1] External complaints are defined by the *Patient Care Quality Review Board Act* and External Complaint Regulation, and may include complaints about services that are not funded or provided by the health authorities, or complaints that are best addressed by another entity – for example, the BC College of Physicians and Surgeons in the case of alleged misdiagnosis.

Overview of Patient Care Quality Review Board Volume, 2009/10

	Reviews accepted	Reviews completed[2]	Cases with recommendations	Cases without recommendations
Fraser Health Authority	10	12	12	0
Interior Health Authority	15	11	9	2
Vancouver Coastal Health	18	13	9	4
Vancouver Island Health	13	10	6	4
Northern Health Authority	2	0	0	0
Provincial Health Services	7	7	7	0
Total	65	53	43	10

The Patient Care Quality Review Boards (the Boards) made a total of 104 recommendations in 2009/10 – 102 to the health authorities and two to the Minister of Health Services (see chart below). Eighty-seven of those health authority recommendations were to improve the quality of patient care, and 15 were to improve the complaints process. In 16 of the completed reviews, the Boards identified opportunities for the Patient Care Quality Offices to improve the quality of its investigation or response; in the remaining 37 reviews, the Boards found the Patient Care Quality Office had responded appropriately.

Board Recommendations to Health Authorities and the Minister of Health Services, 2009/10



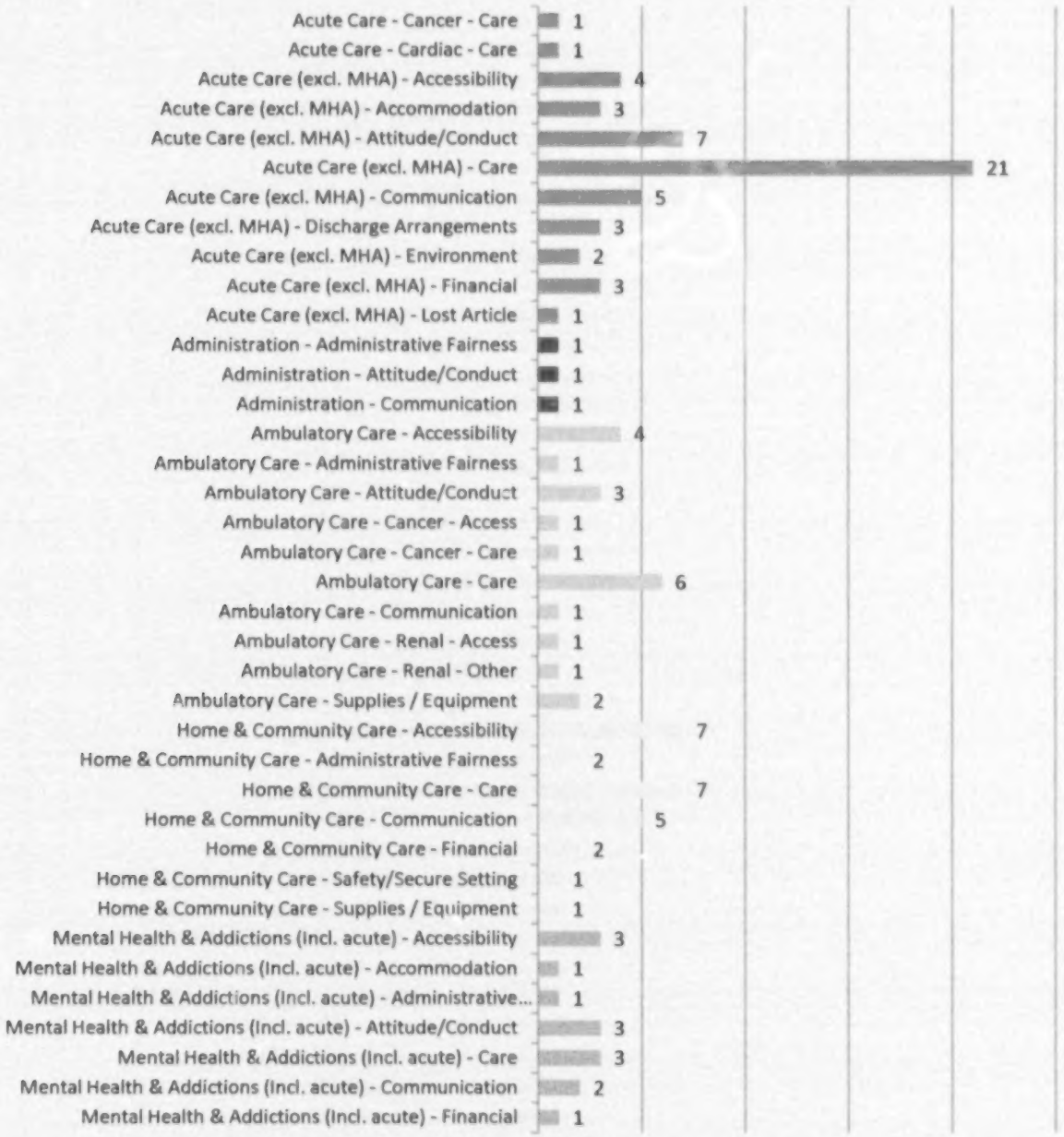
The Boards also collect information regarding the timeliness of health authority responses to Board recommendations. Under the *Patient Care Quality Review Board Act*, health authorities are required to respond to recommendations within 30 business days, not including statutory holidays. Health authorities achieved this timeline in 35 of the 43 reviews that resulted in recommendations (81.0%).

Finally, the Boards track the timeliness of our own reviews. Under the legislation, the Boards are expected to complete those reviews within a maximum of 120 business days. On average, reviews were completed within 99 business days, and in a median time of 107 business days. In four cases, the Boards exceeded this timeline and informed the parties involved.

[2] The number of reviews completed in a fiscal year may be higher than the number of reviews accepted because the Boards have 120 business days to conduct a review and may be completing reviews that were accepted in the previous fiscal year.

Care Quality Issues Reviewed

The graph below represents the subjects of all the complaints reviewed by the Patient Care Quality Review Boards in 2009/10.[3] Note that one complaint typically encompasses more than one care issue, so the total number of care issues will generally always be higher than the total number of complaints reviewed.


Acute Care - Cancer - Care 1
Acute Care - Cardiac - Care 1
Acute Care (excl. MHA) - Accessibility 4
Acute Care (excl. MHA) - Accommodation 3
Acute Care (excl. MHA) - Attitude/Conduct 7
Acute Care (excl. MHA) - Care 21
Acute Care (excl. MHA) - Communication 5
Acute Care (excl. MHA) - Discharge Arrangements 3
Acute Care (excl. MHA) - Environment 2
Acute Care (excl. MHA) - Financial 3
Acute Care (excl. MHA) - Lost Article 1
Administration - Administrative Fairness 1
Administration - Attitude/Conduct 1
Administration - Communication 1
Ambulatory Care - Accessibility 4
Ambulatory Care - Administrative Fairness 1
Ambulatory Care - Attitude/Conduct 3
Ambulatory Care - Cancer - Access 1
Ambulatory Care - Cancer - Care 1
Ambulatory Care - Care 6
Ambulatory Care - Communication 1
Ambulatory Care - Renal - Access 1
Ambulatory Care - Renal - Other 1
Ambulatory Care - Supplies / Equipment 2
Home & Community Care - Accessibility 7
Home & Community Care - Administrative Fairness 2
Home & Community Care - Care 7
Home & Community Care - Communication 5
Home & Community Care - Financial 2
Home & Community Care - Safety/Secure Setting 1
Home & Community Care - Supplies / Equipment 1
Mental Health & Addictions (Incl. acute) - Accessibility 3
Mental Health & Addictions (Incl. acute) - Accommodation 1
Mental Health & Addictions (Incl. acute) - Administrative... 1
Mental Health & Addictions (Incl. acute) - Attitude/Conduct 3
Mental Health & Addictions (Incl. acute) - Care 3
Mental Health & Addictions (Incl. acute) - Communication 2
Mental Health & Addictions (Incl. acute) - Financial 1

[3] Note that the Acute Care category excludes Mental Health and Addictions (MHA) because MHA is its own separate category.

Recommendations and Responses

After completing a review, the Patient Care Quality Review Boards (the Boards) may make recommendations to the health authorities and/or the Minister of Health Services to improve the quality of care and to improve the complaints process.

When making recommendations, the Boards consider:

- The context of the complaint from both the health authority and the patient perspective;
- The policies, procedures, guidelines, etc. that are applicable to the complaint;
- The feasibility of implementing the recommendation;
- The potential impact of the recommendation; and
- The evidence base for the recommendation.

The health authorities carefully consider recommendations and are required to respond within 30 business days to indicate what action(s) will be taken to address the Boards' recommendations.

In 2009/10, the Boards made two recommendations to the Minister and 102 to the health authorities. (Note that the response summaries in this section do not detail every action taken by the health authority to address the Board's recommendation – these are highlights.)

Recommendations to the Minister of Health Services

1. That the Minister consider conducting a review of the provincial policy regarding the prevention and treatment of decubitus ulcers and contractures.

   Summary of Response:

   - The Ministry reviewed this clinical issue and determined that it is appropriately addressed through existing best practice standards and education standards for wound care in B.C. Health authorities manage the prevention and treatment of decubitus ulcers through individual patient care plans as part of general wound care. The Ministry will continue to monitor this issue from a provincial perspective.

2. That the Minister of Health Services examine the current model for the provision of services to children with cerebral palsy to ensure that it continues to meet the needs of the population.

   Summary of Response:

   - The Ministry reviewed information provided by the Provincial Health Services Authority (PHSA), which advised that BC Children's Hospital is currently exploring ways to improve services for children with cerebral palsy. The Ministry requested that PHSA report back on the status of these efforts by summer 2010, for further consideration of next steps.

Recommendations to the Fraser Health Authority (FHA)

1. *Complaint regarding the continuity of care in mental health.*

Recommendation (1):

- The Fraser Health Authority should review their guideline or policy regarding the transitioning of mental health patients from one care provider to another, with a goal to improving it so that issues [such as those highlighted by this case] do not occur again. If no such policy or guideline exists, then the Board recommends that one be written.

Summary of Response:

- FHA developed a policy for implementation across the health authority.

2. *Complaint regarding treatment while involuntarily admitted under the* Mental Health Act.

Recommendations (11):

- That Fraser Health Authority (FHA) ensures that all staff treat patients with respect and dignity no matter what form their presentation at a facility takes.
- That FHA conducts training sessions regarding the discrimination faced by mental health patients. It is the Board's opinion that this training should include all staff who come in contact with patients and not be limited solely to clinical staff.
- That FHA ensure that internal policies and the *Mental Health Act* related to admission of voluntary and involuntary psychiatric patients are followed by providing patients a copy of Form 5 to sign, when appropriate to do so.
- The Board recommends that FHA amend the [patient's] chart and confirm this with the complainant.
- If a patient disclosure policy is not presently in place then the Board recommends that one be developed and that the FHA should review the Vancouver Island Health Authority's policy.
- [The physician's] letter of [DATE] states that patient care is being monitored in the Psychiatric Emergency Department. The Board recommends that FHA continue to supervise staff in the Psychiatric Emergency Department to ensure patients are being treated with respect and dignity.
- The Board is aware of the planned structural changes to the ward and, based upon a goal of creating a safe and calming environment, recommends that FHA consider including improvements to the seclusion room with these structural changes.
- The Board recommends that patients be informed of their rights upon admission and that staff should whenever possible assist them to use a telephone and to find them a lawyer or advocate.
- The Board recommends that FHA post, in plain language, in the psychiatric unit, the FHA Mental Health Act Policy and Procedures as per FHA policy.
- That FHA include a provision in its contracts with its security contractor that sensitivity training, with respect to treating mental health patients with dignity and respect and with the rights of mental health patients, will be provided to all security personnel in a manner approved by FHA.
- That when possible emergency psychiatric patients should be brought in through a different entrance from regular acute emergency patients. In addition, when the hospital is planning renovations FHA should consider adding a separate emergency entrance for psychiatric patients.

Summary of Response:

- *Mental Health Act* policies and their application are included in new employee orientation and have now been added to the ongoing staff refreshers by Clinical Nurse Educators at the hospital in question. Information regarding FHA's *Mental Health Act* policy and procedures has been posted on both inpatient psychiatry units and in the psychiatric ER. The issue of respect and dignity for mental health patients is raised at staff meetings or with individual staff as needed. Expansion and improvements to the psychiatric ER have been included in redevelopment plans for the hospital's emergency department.

3. *Complaint regarding alleged neglect and abuse while involuntarily admitted under the* Mental Health Act.

Recommendations (3):

- That FHA review the Seclusion Room Policy 1.5, so that procedure and process follow policy.
- That FHA provide the complainant with a list of the changes to policy that have already been implemented based on this event.
- That FHA review its training policy for staff regarding the treatment of people suffering with mental health illnesses in regard to respect and dignity.

Summary of Response:

- All Psychiatric Assessment Unit staff will receive enhanced training in Prevention and Management of Aggressive Behaviour (PMAB), and all staff working in Inpatient Psychiatry will receive basic training in PMAB. A session was held for nursing staff to review the relevant policy and process. A revision to the Seclusion Room Policy specifically references the need for patients to be treated with respect and dignity, and this has been communicated to staff.

4. *Complaint regarding alleged misdiagnosis.*

Recommendation (1):

- That FHA provide [the complainant] with specific and substantive answers to their [patient-specific questions].

Summary of Response:

- FHA completed a medical review and provided a response to the questions itemized by the Board.

5. *Complaint regarding pressure sores.*

Recommendations (2):

- That FHA review its policies regarding communication with family members regarding the prognosis and likely outcomes based on the symptoms presented by patients. FHA should ensure that communication is clear, and updated as appropriate, and done on a regular basis.
- That FHA review its policies with regard to facilitation of finding a primary care physician for those in a residential care setting; and ensure that when a patient transitions between facilities there is an adequate exchange of information in regard to the patient's health problems and care plans between the health care facilities and health care professionals.

Summary of Response:

- FHA Residential and Assisted Living Services reviewed policies and processes for communication with residents and family members, and identified opportunities for improvement – including standardizing processes for informing and involving families in developing individualized care plans for each patient. A Resident Review process is also being implemented. FHA is implementing a

standardized Transfer Form that will be used to share information between the residential and acute care sectors when individuals are transferred.

6. *Complaint regarding medication.*

Recommendation (1):

- Especially when faced with serious illness and large family groups, that the health authority be sensitive to the importance of identifying a family spokesperson who is provided with the details, concerns and care needs of the patient and the value of having family conferences to discuss the health issues.

Summary of Response:

- FHA reviewed its communication processes and confirmed that FHA provides opportunities for family conferences whenever possible.

7. *Complaint regarding visiting hours and staff identity.*

Recommendations (4):

- That the health authority review its policies regarding visiting hours. When exceptions to the policy are made, the circumstances should be noted and the situation monitored to ensure that the other patients in that room are not disturbed so that, as much as possible, the hospital room is a comfortable and healing environment.
- That the health authority review its policies regarding the charting of health professional interactions with patients. Health care professionals should chart their visits and should be clearly identified with a name tag. Health care professionals should identify themselves verbally and state their role when interacting with patients and their families.
- That the health authority review the directives issued under the Patient Care Quality Review Board Act which specify that the PCQO must complete its investigation within 30 business days and inform the complainant within an additional ten business days of the outcome of the investigation. The timeline can be increased with permission of the complainant.
- That the health authority review the discharge planning conducted in this case with a view to improving the communication between the team developing the plan and the communication of that plan with the complainant.

Summary of Response:

- Staff were reminded of the policy on visiting hours and encouraged to use private rooms for patients who have visitors after hours due to unusual circumstances. Staff were also reminded of the importance of wearing identification, introducing themselves and their roles to patients, and charting their interactions with patients. These practices are being reinforced and monitored on an ongoing basis. In addition, this case was reviewed with the health care team, and each unit now has daily rounds with all team members to discuss discharge plans with input from the patient.

8. *Complaint regarding care in the emergency department.*

Recommendation (1):

- When it becomes clear to the attending medical and nursing staff that the patient's status has changed from acute care to more chronic care, and the patient requires rehabilitation, consideration should be given to the establishment of therapeutic goals appropriate to the patient's age and ability.

Summary of Response:

- FHA communicated with sites across the health authority about the Board's recommendation and the importance of working with patients and their families to establish appropriate goals. FHA established a region-wide program to ensure coordination and continuity as patients transition from one phase of care to another. FHA also developed a directory and circulated this to staff to help them identify the most appropriate rehab services to meet the patient's needs.

9. *Complaint regarding medical and diagnostic care.*

Recommendations (2):

- That the health authority review the emergency and admitting process relating to [the patient's] care when [the patient] presented to the [Emergency Department], with a view to ensuring that the treatment timelines met standards for determining the well being of the foetus.
- That the health authority review the treatment and supports provided to this patient, with a goal of developing an empathetic care process for mothers with intrauterine death if such a process is not already in place, and reinforcing to staff the need to provide care and support to the grieving parents.

Summary of Response:

- The protocols on perinatal loss will be distributed to the FHA obstetrical team for review and potential implementation across the health authority. The importance of support and the availability of resources for patients and families was reiterated to all staff.

10. *Complaint regarding the continuity of care.*

Recommendations (3):

- That the health authority review the British Columbia Stroke Strategy recommendations and track the progress made to date and ensure that the recommendations are being implemented appropriately, with particular attention to Pillar 3 (Stroke Rehabilitation and Community Integration).
- With a view to planning improvements, the Board recommends that FHA considers tracking the course of selected future stroke patients' rehabilitation to determine whether or not it is being appropriately, consistently, and acceptably administered for the patient and their family.
- That FHA review its current guidelines for the identification of a most responsible health care professional for those in continuing care to ensure that when a patient transitions between facilities there is an adequate and appropriate continuance of the care plan in place, with particular regard for patients requiring intensive rehabilitation.

Summary of Response:

- FHA provided an overview of its progress to date. FHA is currently evaluating its Rehab Program Team and Stroke Strategy work. A consumer focus group is being planned to provide input into the program's 1-3 year goals. The Program Team and Stroke Steering committee reviewed the guidelines and revised these to ensure transitions in care have appropriate continuity with regard to care planning.

11. *Complaint regarding hospital care.*

Recommendations (2):

- That the Fraser Health Authority review the list of questions provided by the complainant to the PCQO and the Review Board, and provide substantive answers to [the] questions.
- That the Fraser Health Authority review the pain management plan for the patient during the time in question to ensure that the provision of medications met practice or procedural guidelines.

Summary of Response:

- FHA answered the complainant's questions and reviewed the care provided in this case. A review of best practices for pain management led to the following recommendations:
  - Educational review on toxicity and side effects presented to physician and nursing rounds;
  - Review and implementation of pain scale, chart and guidelines for acute pain management; and
  - Staff education regarding pain management for cancer patients.

12. Complaint regarding patient transfer and pain management.

Recommendation (1):

- That the health authority review the pain management plan developed for this patient while at [the facility in question] with a view to identifying issues and potential improvements to the pain management program in place for the [facility].

Summary of Response:

- Patient case reviews were held with nursing staff and clinical patient care leader regarding complex nursing care issues, including pain management. FHA implemented the Persistent Pain - Clinical Practice Guidelines in monthly orientation sessions for new nursing staff at the facility in question. Educational presentations were also provided regarding pain management for patients with chronic and acute pain, and there will be ongoing education presentations on this topic throughout 2010.

Recommendations to the Interior Health Authority (IHA)

1. *Complaint regarding access to care for Lyme disease.*

Recommendation (1):

- That the Patient Care Quality Office compile a list of specialists in Infectious Diseases to which the patient may be referred by [the] family physician.

Summary of Response:

- IHA provided the complainant with contact information for Infectious Disease specialists for BC (obtained from the BC College of Physicians and Surgeons). In future, IHA will assist other individuals in locating this type of information.

2. *Complaint regarding wait time to be placed in a funded bed.*

Recommendation (1):

- That the Health Authority consider that in cases of staff vacation or illness in the PCQO, files be delegated to other staff for timely responses and general communication with complainants as is required by the Ministerial Directives under the *Patient Care Quality Review Board Act*.

Summary of Response:

- IHA confirmed this is the usual standard practice and recently implemented the Complaints Module in the Patient Safety Learning System, which will help ensure individuals receive timely communication.

3. *Complaint regarding discharge and travel arrangements.*

Recommendations (5):

- That the Health Authority issue an apology regarding the discharge and transportation arrangements that [the patient] received.
- That the Health Authority review the discharge planning policy with consideration given to this particular case.
- That the discussions between staff and patients and their families be reviewed with a mind to ensure that discharge options are not construed as discharge plans.
- That discharge planning encompass considerations of medical condition, the distance required to travel and the method of transportation.
- That the Health Authority review the storage and protection of valuables and identification for out-of-town patients.

Summary of Response:

- IHA discussed this recommendation at a Quality and Patient Safety Committee meeting and decided to prioritize development of the Clinical Practice Standard Supporting the Clients and Families Through the Healthcare System, with particular attention to discharge planning. IHA will review its policy on client valuables and personal effects in 2011.

4. *Complaint regarding pressure sores and access to the Patient Care Quality Office.*

Recommendations (4):

- That in future, family or care representative be provided with a clear understanding of the likelihood of pressure sores developing in patients with pre-existing conditions such as were present in this case.
- That in future cases staff attempt to engage the patient's family in encouraging compliance with staff care requests.
- That the nursing staff, the wound care nurse, and the plastic surgeons at [the hospital in question] review the policy regarding the prevention and treatment of pressure sores in high risk patients.
- That the health authority ensure that the staff are aware of the PCQO and how patients can contact them. Also staff should be made aware that if a complaint cannot be resolved at the unit level that a complainant should be referred to the PCQO.

Summary of Response:

- Future revisions to IHA's wound care manual may include the addition of "patient and family" to the definition of multidisciplinary pressure ulcer prevention team. The PCQO will review staff awareness as part of a one-year review.

5. *Complaint regarding nurse conduct and attitude.*

Recommendations (3):

- That [the nurse's] supervisor conduct a thorough review of the matter as [the Board] believes the supervisor is the most appropriate person to address matters of questionable behaviour.
- That in cases of questionable behaviour by a health authority staff member, that the PCQO copy the supervisor of the staff member in question in all communications regarding the complainant.
- That PCQO staff be provided with an opportunity to attend professional development training targeted at written communication.

Summary of Response:

- The manager was advised of the concerns for appropriate follow-up. IHA will seek professional development training for its Patient Care Quality Officers as needed.

6. *Complaint regarding haemodialysis services.*

Recommendation (1):

- That the health authority find a senior independent person, possibly through the BC Renal Agency, to look into the concerns of the patient and the care providers in [the community] and work with them to develop a new care plan that contains consequences for non-compliance on the part of the patient. The care plan should include counselling for the patient prior to being able to return to [the community] if it is decided that it would be appropriate to provide service there again.

Summary of Response:

- This recommendation is under further consideration. IHA did confirm that alternative services may include home haemodialysis or haemodialysis treatment in another community.

7. *Complaint regarding the residential care rate.*

Recommendations (2):

- That the residential care rate assessment be reassessed by the Interior Health Authority.

- That the health authority review its communications with [the complainant] in this file to determine how they could have been improved to clarify the proper procedure for requesting a review of the rate set in [this] case.

Summary of Response:

- IHA reviewed the communications in this case, and in future will include a brochure on the appeals process in all future decision letters regarding residential care rates.

8. *Complaint regarding home support services.*

Recommendations (4):

- That the health authority review the placement of log books at the home of clients.
- That the health authority review the training provided to care aides with regard to dealing with difficult clients.
- That the health authority review the policies regarding the use of care aides of a different gender than their clients for bathing needs.
- That a senior representative of Home Support & Long Term Care...meet with [the complainant] and/or [the complainant's] advocate.

Summary of Response:

- The recommendations were forwarded to the Home and Community Care leadership team for review. IHA will consider the use of electronic logbooks in the future.

9. *Complaint regarding hospital charges.*

Recommendation (1):

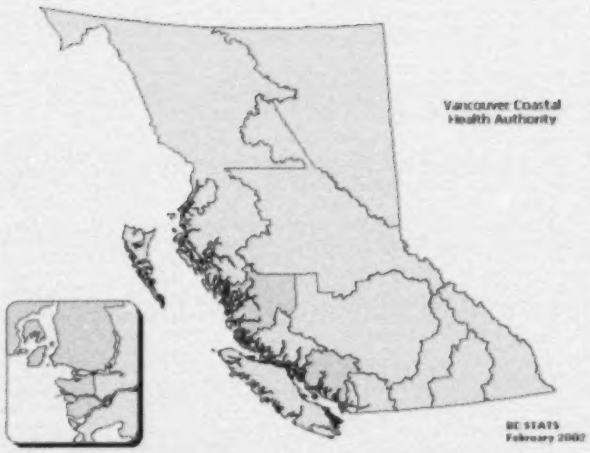
- That the health authority ensure that when discussing the costs associated with the provision of services to someone without insurance, that the discussion be inclusive of both medical and hospital services costs including potential additional costs associated with complications or extended stays.

Summary of Response:

- The pamphlet outlining the charges for out-of-country patients has been reviewed, with a number of significant changes proposed. These changes may be included when the pamphlet is next updated.

Recommendations to the Vancouver Coastal Health Authority (VCHA)

1. ***Complaint regarding application of the first available appropriate bed policy.***



Recommendations (3):

- The Board recommends that the Vancouver Coastal Health Authority review their current placement policy and ensure that it is understandable, explainable, fair and straightforward to apply.
- The Board recommends that the Vancouver Coastal Health Authority review their current communication material, so that the policy and the discretion used in its application regarding temporary suspension from the [Assessed and Awaiting Placement] waitlist is clear to the patients and their families. The Board also suggests that the health authority consider using a visual aid to explain the waitlist process, and the various possible pathways a patient may take while moving through varying levels of care.
- The Board recommends that the Vancouver Coastal PCQO examine their communication policies, and in cases where appropriate, consider facilitating a meeting between the responsible administrator and the patient or the patient's family.

Summary of Response:

- VCHA is reviewing the policy and communication tools to ensure language is consistent and clear. Once complete, this work will be shared with the VCH Complex Residential Care Working Group for consideration and implementation across VCHA. The communication materials were improved for patients and family members, and a training program was provided for relevant staff to ensure clients receive clear and consistent communication. Once complete, this work will also be shared with VCH Complex Residential Care Working Group for consideration and implementation across VCHA.

2. ***Complaint regarding Methicillin-Resistant Staphylococcus Aureus (MRSA).***

Recommendations (4):

- That the Health Authority reviews the effectiveness of the "Regional Overcapacity Protocol Guidelines for Transfer of Admitted Patients from the Emergency Department" and include a plan to update and finalize the guidelines.
- That the Health Authority consider identifying clearly on a patient chart whether or not a patient is immuno-compromised, so that when the guideline is enacted it is clearer which patients can be moved into rooms such as those with patients infected with MRSA.
- That the Health Authority review the adherence to policy with regard to infection control measures at intake and ensure that when a patient answers yes to one of the infection control questions that they are then screened for antibiotic-resistant bacteria.
- That intake forms are signed and dated as required, by the health professionals involved in the care of an individual.

Summary of Response:

- Providence Health Care undertook a formal evaluation of its overcapacity protocol guidelines, and shared this evaluation with its other health service delivery areas. VCHA will also encourage the local review of these guidelines throughout its health service delivery areas. VCHA has taken a number of steps to optimize adherence to the protocols for screening patients considered at risk for an antibiotic-resistant organism, including embedding forced functions in clinical information systems, and the use of paper documents designed to remind and encourage compliance. VCHA will work with the Health Authority Interprofessional Advisory Council to consider mechanisms by which compliance can be improved.

3. *Complaint regarding staff attitude and "Do Not Attempt CPR" protocol.*

Recommendations (3):

- The Board recommends that the health authority review its policy regarding informing the patient's family of the [Do not attempt CPR] protocol to ensure that the purpose is clear and that family members are able to understand what is meant by such an order.
- The Board recommends that the health authority further consider including clear and direct language on their consent for autopsy forms:
    - Indicating the form is not a requisition form,
    - Clarifying that the form merely gives authorization to the health authority to conduct an autopsy, and,
    - Stating that an autopsy may not be conducted if the attending physician or health authority in their opinion does not feel it is necessary.
- The Board further recommends that if a consent form is presented to and signed by the deceased person's next of kin and/or executor/administrator, the health authority should be notified and make a timely communication to the next of kin if a decision not to conduct an autopsy is made.

Summary of Response:

- VCHA will discuss strategies to address this recommendation at the Quality of Care Committee of the Health Authority Medical Advisory Committee. VCHA also engaged in further investigation with Laboratory and clinical staff leaders to reinforce process and systems to clarify understanding and use of the consent for autopsy forms.

4. *Complaint regarding communication.*

Recommendation (1):

- The Board recommends that the health authority review the access to professional interpretive services for non-English speaking patients, so that the patients and their family are able to effectively communicate their concerns to their health care providers and in turn the health care providers can be assured that patients and their families understand the information that is communicated to them.

Summary of Response:

- VCHA ensures effective communication with patients informally through family (when the patient agrees to have family involved) or multi-lingual staff, and provides access to formal interpreter services through PHSA's Provincial Language Service (the PLS).

5. *Complaint regarding alleged misdiagnosis and hospital charges.*

Recommendations (3):

- That the health authority examine its policy regarding out-of-country patients, and consider ensuring that the costs of treatment for those without insurance are clearly identified and updated during the patient's stay.
- That the Vancouver Coastal Patient Care Quality Office review the correspondence produced in this case, with a view to improving the messaging, so that patients and their families can see that the health authority is working within the confines of the BC health care system and must attempt to retrieve costs owed to them.
- That the health authority consider working through its community liaison office to develop information notices for residents that may have family members visiting them. The information should include the fact that there will be costs incurred to those without insurance and the benefits of travelling with insurance.

Summary of Response:

- The PCQO is working with Finance to provide an information resource with basic information about the process for dealing with uninsured patients and to ensure clear communication in correspondence. A form has been developed outlining the basic charges applicable to uninsured BC residents and visitors to Canada, and work is being done to ensure these are used throughout the health authority. The PCQO is also working with Community Engagement and other partners to increase awareness in the broader community of the importance of having health insurance.

6. *Complaint regarding care in the Emergency Department.*

Recommendation (1):

- That the health authority review their practices for patients being treated in the emergency department to determine if there is a methodology available for reducing the anxiety of patients.

Summary of Response:

- VCHA reviewed its practices with ED physician and clinical leaders and determined there was no blanket methodology available for reducing patient anxiety. Overall, VCHA tries to reduce patient anxiety by expediting their access to a physician. VCHA will share this recommendation with the Regional Emergency Services Council for their information and learning.

7. *Complaint regarding eviction from group home.*

Recommendations (2):

- That the Vancouver Coastal Health Authority review the initial investigation and reporting done with regard to this complaint.
- That the Vancouver Coastal Health Authority review the events of [DATE] with a view to improving the processes by which patients are informed of changes in the services being delivered.

Summary of Response:

- VCHA reviewed the initial investigation and identified opportunities for quality improvement in terms of the reporting of and responding to complaints. This case and recommendation were reviewed by the Coastal Mental Health Services Quality Committee, and will be discussed by Regional Mental Health Services Operations Directors for consideration of further action.

8. *Complaint regarding mislabelling of lab tests.*

Recommendations (2):

- That the Vancouver Coastal Health Authority further review this matter to identify where the breakdown in process occurred and to put in place sufficient additional policy, guidelines or practices to prevent this matter from recurring.
- That the Vancouver Coastal Health Authority examine the investigation done by health authority staff to identify improvements that could be made to ensure that in future a thorough clinical assessment is performed in regard to complaints of this nature.

Summary of Response:

- The matter was reviewed. Providence Health Care's Renal Program has instituted an updated procedure for lab collection and educated staff on this. A new policy regarding conflicting lab results has also been adopted.

9. *Complaint regarding post-operative monitoring.*

Recommendations (3):

- That the health authority use their review of the matter for educational and teaching purposes as was recommended by the BC Coroner's Office.
- That the health authority take note of and analyze the questions submitted to the Board by the complainants... with a sincere goal of improving the complainants' understanding of the events and also identifying to the complainant that an appropriate investigation into the event was performed. Further, if found to be appropriate, that the complainants be informed as to what measures were being instituted to prevent any similar occurrences.
- That the health authority review the standards of practice regarding the monitoring of patients post surgery to ensure that the monitoring is comprehensive particularly for patients who are at increased respiratory/cardiac risk due to pre-existing neurological/behavioural conditions.

Summary of Response:

- This case will be included in ongoing teaching about collaborative practice, and will specifically be reviewed during further development and ongoing quality initiatives concerning collaborative practice. The event will be summarized in an Event Learning Summary, for distribution across VCHA as well as the other health authorities. VCHA initiated a task group to review the existing practice guidelines and supports for practice concerning post operative monitoring.

Recommendations to the Vancouver Island Health Authority (VIHA)

1. *Complaint regarding care provided by community health workers.*

Recommendation (1):

- That the PCQO ensure that when facilitating complaints regarding contracted or private services that the investigation and follow-up for the complaint be completed through the PCQO rather than through the contracted or private service. *[The Board later clarified this recommendation, indicating that the PCQO should have an oversight/coordination role of the investigation, rather than conduct the investigation.]*

Summary of Response:

- VIHA will continue implementing current initiatives to ensure that staff refer complainants to the PCQO as appropriate.

2. *Complaint regarding care provided in the Emergency Department.*

Recommendations (2):

- That [the hospital] review its follow-up procedures to ensure that adequate follow-up is done by the emergency department and/or the attending physician.
- That VIHA reconsider the reimbursement request for the MRI made by the complainant and exercise its discretion in favour of making the payment.

Summary of Response:

- VIHA reviewed its follow-up processes and confirmed that common practice is for follow-up to be done through the family physician or the emergency physician. This common practice will be developed into an island-wide protocol. The reimbursement request was considered in the context of applicable provincial policy and the *Canada Health Act*.

3. *Complaint regarding hospital discharge and hospitalists.*

Recommendations (2):

- That the Health Authority formulate a written policy regarding patients who refuse to leave an acute care bed once the health professionals responsible for their care have deemed them ready for discharge.
- That the Health Authority formulate a written policy regarding requests from patients to change their hospitalist.

Summary of Response:

- The health authority confirmed that a policy regarding patients who refuse to leave acute care is already in place, but had not been invoked while the health care providers attempted to exhaust all other means of resolution.

4. *Complaint regarding design of leg bags.*

Recommendation (1):

- That the health authority review its investigation and response into this matter and consider it from a clinical point of view rather than from an administrative point of view.

Summary of Response:

- VIHA reviewed its investigation and response, and confirmed the matter was considered from a clinical point of view. The complainant's feedback regarding the design of the leg bags may be considered during future procurement processes.

5. *Complaint regarding medication.*

Recommendations (2):

- That the health authority further review the matter, with particular attention to the medication provided to the patient on the Medication Administration Record Sheet, and the type and colour of the pills available in the pharmacy at the time.
- That the health authority provide the complainant with a list of the medications administered on the night of [DATE] and the morning of [DATE], along with information regarding the colour and dosage of pills.

Summary of Response:

- VIHA reviewed the medications provided and gave the complainant the list of medications administered on the evening and morning in question as well as a copy of the Medication Administration Record.

6. *Complaint regarding MRI waitlist.*

Recommendation (1):

- That the Health Authority ensure more equitable access and wait times for patients requiring an MRI. This could be done through a review of their process and systems for booking MRIs across the Health Authority and should include determining the feasibility of creating a central booking office or system for all scheduled MRIs.

Summary of Response:

- VIHA has begun exploring the feasibility of implementing a centralized booking system for medical imaging. To that end, VIHA has established a single, island-wide information system.

Recommendations to the Northern Health Authority (NHA)

1. *Complaint regarding occupational therapy services.*

While the Patient Care Quality Review Board members reviewed this case before March 31, 2010, final decisions were not issued within the fiscal year.

Information regarding the Board's findings and the health authority's response, if required, will be included in the 2010/11 annual report.

Recommendations to the Provincial Health Services Authority (PHSA)

1. *Complaint regarding adverse event at BC Children's Hospital.*

Recommendations (3):

- **That the Health Authority review their policy regarding the scheduling of staff qualified for and designated to insert IV lines. This review should consider the number of patients requiring IV access at any one time and the need for and availability of designated staff to insert IV lines and manage IV therapy.**
- **That the staff of the PCQO be offered the opportunity to take professional development training in regard to their oral and written communication with complainants with a focus on complaint management.**
- **That the PCQO review the Patient Care Quality Review Board Act and Ministerial Directives regarding the requirements for responding to a complaint as well as the documentation required during an investigation.**

Summary of Response:

- **PHSA reviewed the above-mentioned policy and confirmed that an algorithm to access IV services in off-hours is in place and is posted on all units. Bed utilization meetings are held nightly, at which time it is determined which staff are available to start IVs if needed. PHSA also increased the number of IV certification workshops for nurses and paediatric residents (physicians). All paediatric residents complete this workshop during orientation and again throughout their residency. PHSA will continue to improve the way the PCQO handles complaints, and has ensured that staff are familiar with the legislation and directives.**

2. *Complaint regarding access to care for Lyme disease.*

Recommendations (3):

- **That the [BC Centre for Disease Control] provide a copy of the laboratory guidelines to the patient.**
- **That the BCCDC results should be presented in adequate detail for a physician attending on the complainant to be able to deduce the clinical relevance of the results. Special tests should also include an expert interpretation of the test results. These results should be made available to the patient upon request.**

- That PHSA, in collaboration with other professional bodies such as BCCDC, UBC Faculty of Medicine and BC Medical Association, consider establishing an expert review panel that would make recommendations related to the diagnosis, treatment and follow-up and possible knowledge generation from ethical clinical trial investigation, for patients presenting with signs and/or symptoms for which a cause cannot be identified and which might be a consequence of an infectious disease or for which antibiotics might be considered therapeutic.

Summary of Response:

- Guidelines were provided to the complainant. PHSA advised that BCCDC and PHSA staff are available to provide consultative services to clinicians to assist with the interpretation of lab results. PHSA supports participation in the multi-disciplinary approach recommended.

3. *Complaint regarding communication.*

Recommendation (1):

- That the BC Cancer Agency Radiation Therapy Program review its patient reception process to ensure that the voiced concerns of patients are listened to and brought to medical attention. Despite the radiation facility's speciality function and time constraints, it is the Board's belief that the BC Cancer Agency should try to determine whether there might be hidden or unappreciated barriers to effective communication between patients and staff at treatment sessions and specifically during the reception process.

Summary of Response:

- PHSA conducted an incident review and identified opportunities for quality improvement. Going forward, a Radiation Therapist will assess and triage the patients in reception to determine the urgency for physician assessment. Phone inquiries will be handled similarly and prompt an ER referral if needed.

4. *Complaint regarding spinal surgery waitlist at BC Children's Hospital.*

Recommendations (6):

- *Interim recommendation:* That PHSA review the urgency of [the patient's] surgery.
- *Interim recommendation:* That there should also be a full review the entire waitlist
- That the health authority review the waitlist for scoliosis surgery at BC Children's Hospital.
- That the health authority review how surgical procedures are prioritized with a view to implementing a consistent policy for application across the spectrum of surgical procedures performed at the BC Children's Hospital.
- That the health authority consider developing an improved process for the management of paediatric surgery province-wide, and consider making surgical waitlist information for the BC Children's Hospital publically available.
- That the health authority review their resources with a view to determining how to increase the ability of their surgical staff and facilities to provide essential paediatric surgery within a reasonable and appropriate time.

Summary of Response:

- PHSA advised that BC Children's Hospital is reprioritizing the waitlist and that if surgery cannot occur within a medically acceptable timeframe, BCCH will offer alternatives, including surgery at another centre with capacity. PHSA indicated that BCCH has already increased the number of these surgeries from 8 to 13 per month (a 60% increase). Steps are also being taken to improve the process for managing paediatric surgery province-wide. PHSA is currently collecting and analyzing wait-time performance data.

5. *Complaint regarding care at Riverview Hospital.*

Recommendations (2):

- That the health authority review this case with special attention to understanding how mental illness and the medications used to treat it might mask serious and life-threatening physical illness.
- That the Patient Care Quality Office (PCQO) review the investigation of this case and the response to the complainant in order to ensure that the matter was a learning experience for the health authority and that the correspondence effectively conveys the importance that the health authority places on the matter.

Summary of Response:

- Riverview Hospital conducted a quality review, resulting in changes in policy and procedures, as well as continuing education related to the physical status of patients. BC Mental Health and Addiction Services (BCMHAS) has implemented a joint review of patients by nursing and medical staff prior to hospital leaves, as well as a new assessment tool. BCMHAS has shared the learning from this review with staff, and developed a new policy on Nursing Assessment Prior to Patient Leaves.

6. *Complaint regarding the presence of third parties in Operating Room.*

Recommendation (1):

- That the health authority, in consideration of the needs and interests of patients, and in consultation with the medical staff, review the practice of allowing family members and others not part of the surgical team to be present in the Operating Room during part or all of a surgical procedure and develop a policy statement for the guidance of medical staff and for the information of patients and their families.

Summary of Response:

- In consultation with operating room staff, BC Women's Hospital is developing a policy regarding the presence of third parties in the operating room.

7. *Complaint regarding hip surgery waitlist at BC Children's Hospital.*

Recommendation (1):

- That the health authority review the waitlist for hip surgery at BC Children's Hospital.

Summary of Response:

- PHSA reviewed the waitlist and acknowledged that it is unacceptably long. PHSA has already made efforts to reduce the waitlists at BC Children's Hospital, and a new Operating Room Allocation Methodology will be implemented spring/summer 2010.

Conclusion

When individuals have concerns about the quality of care they or a loved one received, it is important that those concerns are appropriately and adequately addressed. This helps to restore the patient's trust and confidence in the health care system, and, on a broader scale, creates opportunities for the health care system to learn from each patient experience. To that end, the Patient Care Quality Review Boards play a central role in enabling those concerns to be heard, to be carefully considered, and to generate ideas for quality improvement at the local, regional and system-wide level.

Over the past year, the Boards' work has highlighted the importance of effective communication in health care. We have seen that even when the quality of care is good, patients can still experience it negatively based on the quality of communication. Indeed, many of the complaints reviewed in 2009/10 resulted from poor communication, and most included a communication issue.

Accordingly, many of the Boards' recommendations in 2009/10 focused on improving communication in the health care system – whether enhancing the sensitivity of communication at the point of care, clarifying information provided to patients, or identifying and removing barriers to effective communication. Already, the Boards have noticed a marked improvement in how health authorities communicate with patients during the complaints process – providing more fulsome, empathetic and timely responses to their concerns.

Certainly, there is ample opportunity to learn from the patient experience – and in the year ahead, each complaint the Boards review will become part of the growing body of evidence that supports a move towards real and lasting change throughout the health care system.

Appendix A: Recommendations and Responses, 2008/09

Established in October 2008, the Patient Care Quality Review Boards completed four reviews in 2008/09 – two of which resulted in a total of ten recommendations (eight to the Interior Health Authority and two to the Minister of Health Services).

Recommendations to the Interior Health Authority

1. *Complaint regarding inter-facility patient transfer.*

Recommendation (3):

- That Interior Health Authority staff be provided with a notice or memorandum and training regarding communication with patients and families with regard to what they should or should not say when patients are being transferred to another facility.
- That all patients if able and/or their family members be provided with a brochure in plain language at the time of transfer informing them of the policy regarding inter-facility transfers including the potential that the patient might not be returned to the originating hospital if they are discharged.
- Recognising that recording every conversation with a patient or patient's family is not practical or reasonable... that health authority staff record communications made regarding future services, referrals and cost implications.

Summary of Response:

- IHA is ensuring that education on inter-facility patient transfers is included in orientation for all new staff. IHA reviewed the information sheet on ambulance transfer and will incorporate the Board's suggestions in the next revision. Once complete, IHA will send the memo and revised brochure to all clinical managers and educators, as well as to all Social Work and Discharge Planner staff. Information on this topic was also published in IHA newsletters.

2. *Complaint regarding alleged negligence and misdiagnosis.*

Recommendation (5):

- That the Patient Care Quality Office (PCQO) ensure that when responding to complainants following their investigations, especially in matters as serious as this, that the responses be complete and done in a timely manner. In addition, the investigations of the PCQO should be done in a professional manner.
- The Board requests assurance from IHA, that the recommendations included in the Interior Health – Comparison of Recommendations from Three Sources Document have been followed and fully implemented.
- That a copy of the Sepsis Treatment Order Set referred to in recommendation two, be sent to the Complainant and that an additional copy is provided to the Review Board.
- That IHA use the vital signs guidelines suggested by the College of Physicians and Surgeons and included by IHA as part of the Alcohol Withdrawal Order Set, to create a Vital Signs Order Set to be used by nursing staff in rural/remote facilities to trigger a call to a physician. The Board recognizes the limitations on creating an order set that is both malleable enough to allow for the uniqueness of each situation, but rigid enough to prevent situations such as the one before us today from occurring again. Once this order set is developed the Board encourages IHA to ensure that proper training is provided to all staff regarding its implications.
- That IHA provide the necessary training and follow-up to ensure that all charting of patient files be done in a full and complete manner.

Summary of Response:

- IHA has continued to improve its client relations function through the PCQO. IHA is reinforcing the use of the Situation-Background-Assessment-Recommendation (SBAR) communication technique for responding to clinical deterioration. The use of this tool will be monitored and supported across IHA. Audits of health records are conducted periodically (either in response to an incident, or as part of a quality improvement initiative.)

Recommendations to the Minister of Health Services

The Board made two recommendations to the Minister in 2008/09, as follows:

1. That the Minister consider whether the Sepsis Treatment Order Set referred to in [the Interior Health – Comparison of Recommendations from Three Sources Document] should be implemented on a province-wide basis, especially in level one hospitals.
2. That the Minister consider whether a Vital Signs Order Set based on the parameters suggested in [the Board's] review be implemented on a Province-wide basis, especially in limited service rural/remote facilities.

Summary of Response:

- The Ministry referred the Board's recommendations to the provincial Acute Care Council for further study and advice. The Council subsequently advised that an appropriate provincial Sepsis Treatment Order Set already exists within British Columbia. A sepsis protocol was recently developed and is already in use and/or being implemented within all health authorities. The Council also advised that a Vital Signs Order Set was not considered feasible or appropriate for implementation. The Ministry will monitor these issues from a provincial perspective, particularly as the Board's body of evidence develops.

Appendix B: Patient Care Quality Office Volume

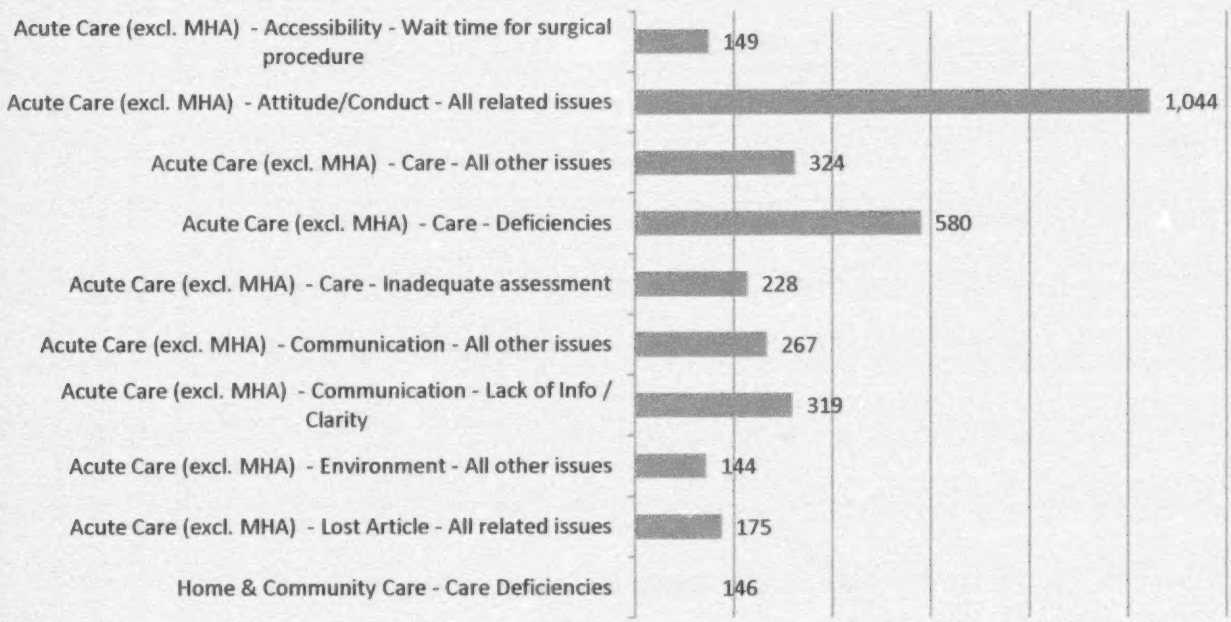
Appendix B details the volume of all complaints and inquiries received by the health authority Patient Care Quality Offices (PCQOs) in 2009/10, and shows the top ten issues, or subjects of complaint, within the province and each health authority.[4]

British Columbia

PCQO Volume, British Columbia, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	67	59	94	89	**309**
Care Quality Complaints	1427	1575	1417	1405	**5,824**
Inquiries	192	248	416	534	**1,390**
Total Volume	1,686	1,882	1,927	2,028	**7,523**

PCQO Top 10 Issues, B.C., 2009/10


Acute Care (excl. MHA) - Accessibility - Wait time for surgical procedure
149
Acute Care (excl. MHA) - Attitude/Conduct - All related issues
1,044
Acute Care (excl. MHA) - Care - All other issues
324
Acute Care (excl. MHA) - Care - Deficiencies
580
Acute Care (excl. MHA) - Care - Inadequate assessment
228
Acute Care (excl. MHA) - Communication - All other issues
267
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
319
Acute Care (excl. MHA) - Environment - All other issues
144
Acute Care (excl. MHA) - Lost Article - All related issues
175
Home & Community Care - Care Deficiencies
146

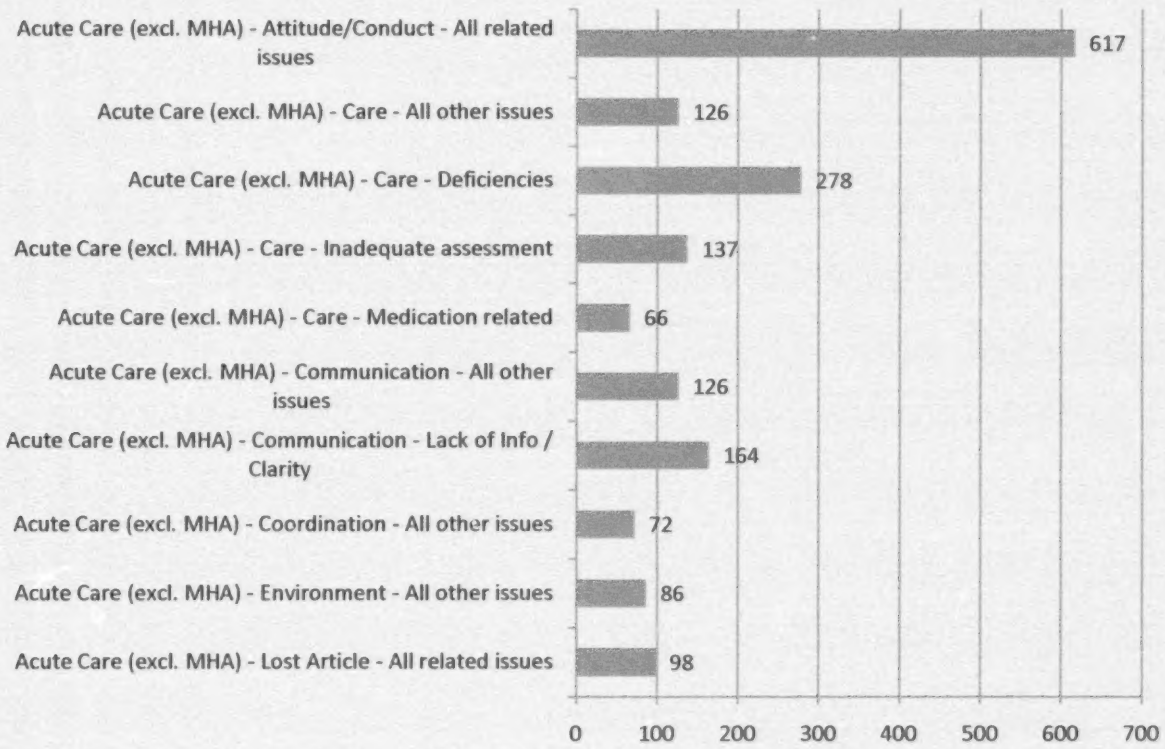
[4] The Patient Care Quality Offices categorize patient complaints using a common reporting framework. Complaints are first categorized according to health sector – including Acute Care, Ambulatory Care, Emergency Care, Home and Community Care, Mental Health and Addictions, Residential Care, and Public Health, among others – then further broken down by subject. Note that one complaint typically encompasses more than one care issue, so the total number of care issues will generally always be higher than the total number of complaints.

Fraser Health Authority (FHA)

PCQO Volume, FHA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	1	2	12	11	**26**
Care Quality Complaints	532	553	495	577	**2,157**
Inquiries	37	31	75	83	**226**
Total Volume	570	586	582	671	**2,409**

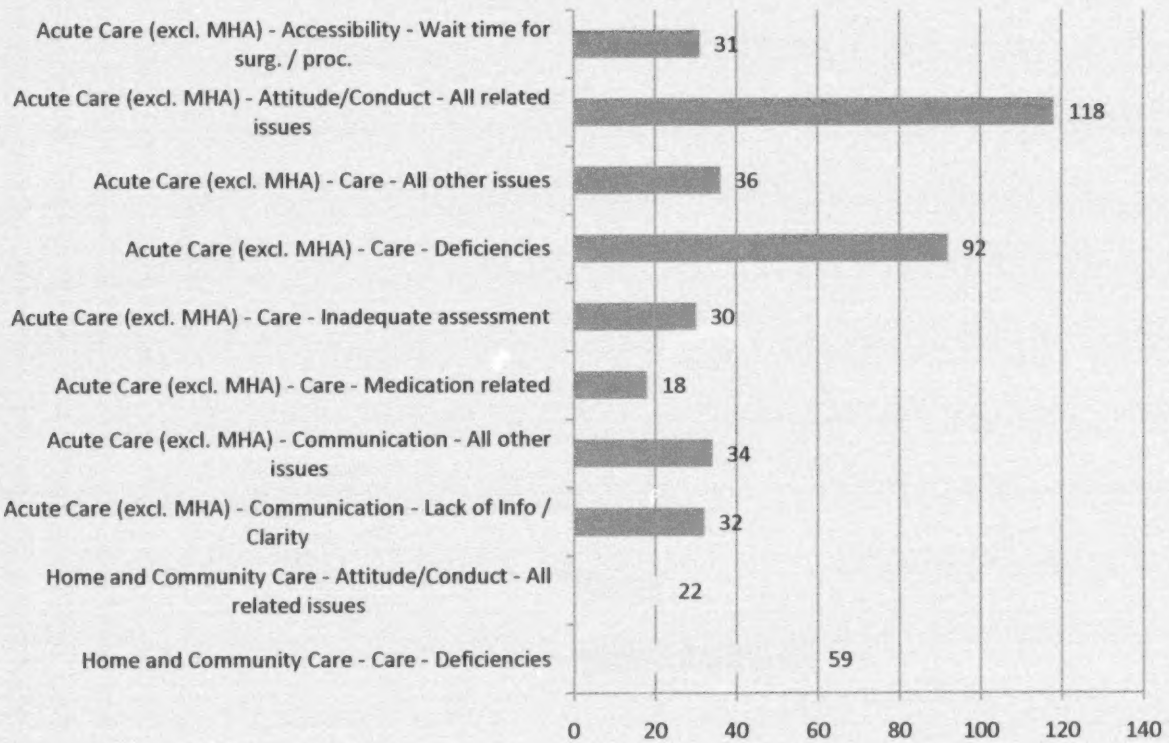
PCQO Top 10 Issues, FHA, 2009/10


Acute Care (excl. MHA) - Attitude/Conduct - All related issues
617
Acute Care (excl. MHA) - Care - All other issues
126
Acute Care (excl. MHA) - Care - Deficiencies
278
Acute Care (excl. MHA) - Care - Inadequate assessment
137
Acute Care (excl. MHA) - Care - Medication related
66
Acute Care (excl. MHA) - Communication - All other issues
126
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
164
Acute Care (excl. MHA) - Coordination - All other issues
72
Acute Care (excl. MHA) - Environment - All other issues
86
Acute Care (excl. MHA) - Lost Article - All related issues
98
0
100
200
300
400
500
600
700

PCQO Volume, IHA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	26	16	29	33	**104**
Care Quality Complaints	160	209	215	244	**828**
Inquiries	12	23	27	33	**95**
Total Volume	198	248	271	310	**1,027**

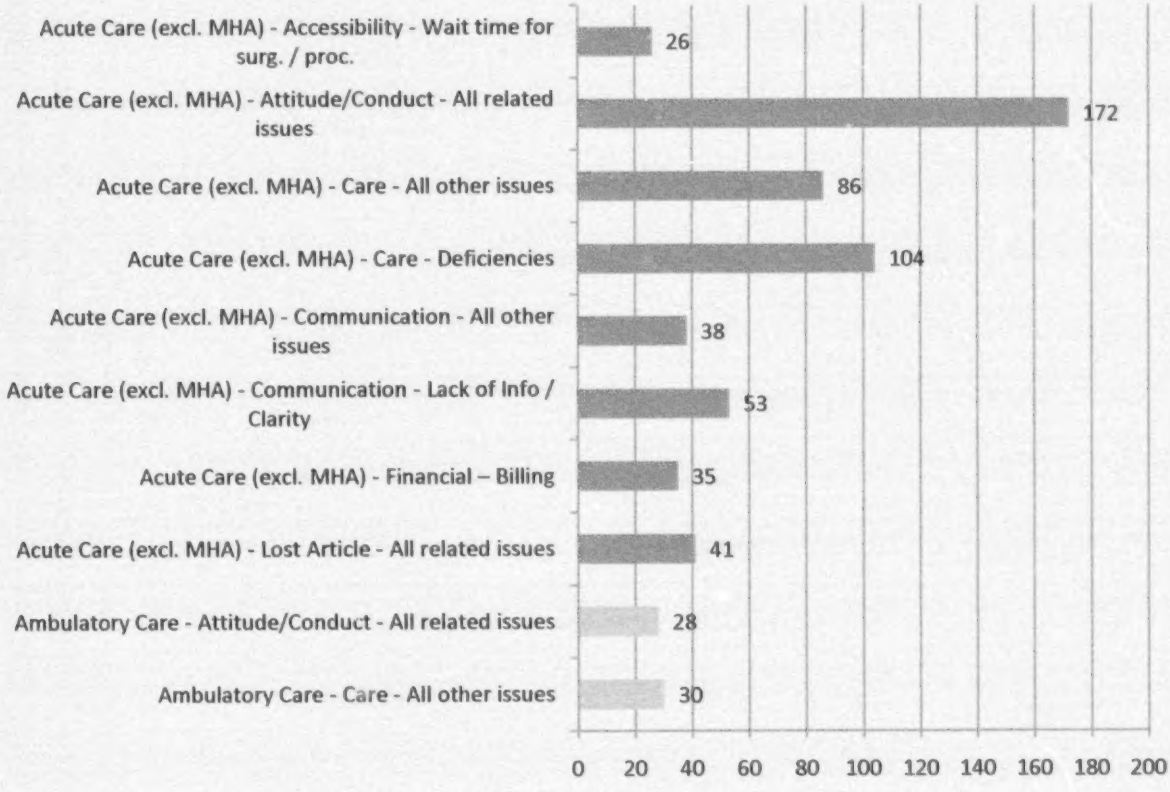
PCQO Top 10 Issues, IHA, 2009/10


Acute Care (excl. MHA) - Accessibility - Wait time for surg. / proc.
31
Acute Care (excl. MHA) - Attitude/Conduct - All related issues
118
Acute Care (excl. MHA) - Care - All other issues
36
Acute Care (excl. MHA) - Care - Deficiencies
92
Acute Care (excl. MHA) - Care - Inadequate assessment
30
Acute Care (excl. MHA) - Care - Medication related
18
Acute Care (excl. MHA) - Communication - All other issues
34
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
32
Home and Community Care - Attitude/Conduct - All related issues
22
Home and Community Care - Care - Deficiencies
59
0
20
40
60
80
100
120
140

PCQO Volume, VCHA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	5	5	12	5	**27**
Care Quality Complaints	214	217	202	221	**854**
Inquiries	22	29	37	70	**158**
Total Volume	241	251	251	296	**1,039**

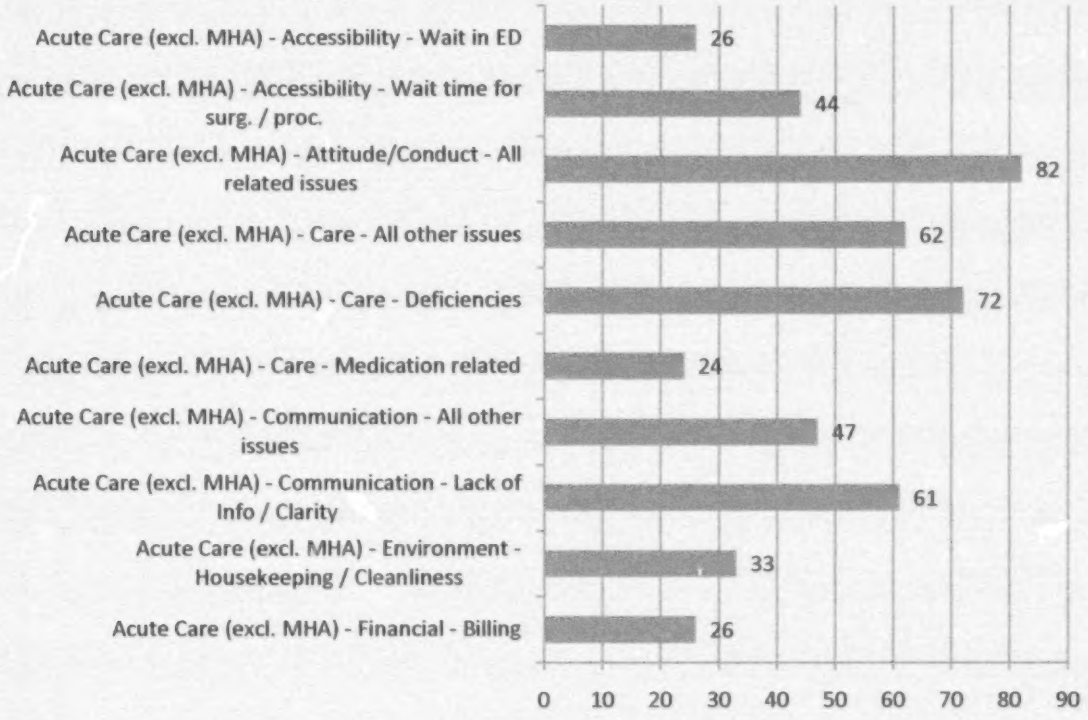
PCQO Top 10 Issues, VCHA, 2009/10


Acute Care (excl. MHA) - Accessibility - Wait time for surg. / proc.
26
Acute Care (excl. MHA) - Attitude/Conduct - All related issues
172
Acute Care (excl. MHA) - Care - All other issues
86
Acute Care (excl. MHA) - Care - Deficiencies
104
Acute Care (excl. MHA) - Communication - All other issues
38
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
53
Acute Care (excl. MHA) - Financial – Billing
35
Acute Care (excl. MHA) - Lost Article - All related issues
41
Ambulatory Care - Attitude/Conduct - All related issues
28
Ambulatory Care - Care - All other issues
30
0 20 40 60 80 100 120 140 160 180 200

PCQO Volume, VIHA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	9	10	21	23	**63**
Care Quality Complaints	431	517	412	259	**1,619**
Inquiries	27	114	199	242	**582**
Total Volume	467	641	632	524	**2,264**

PCQO Top 10 Issues, VIHA, 2009/10

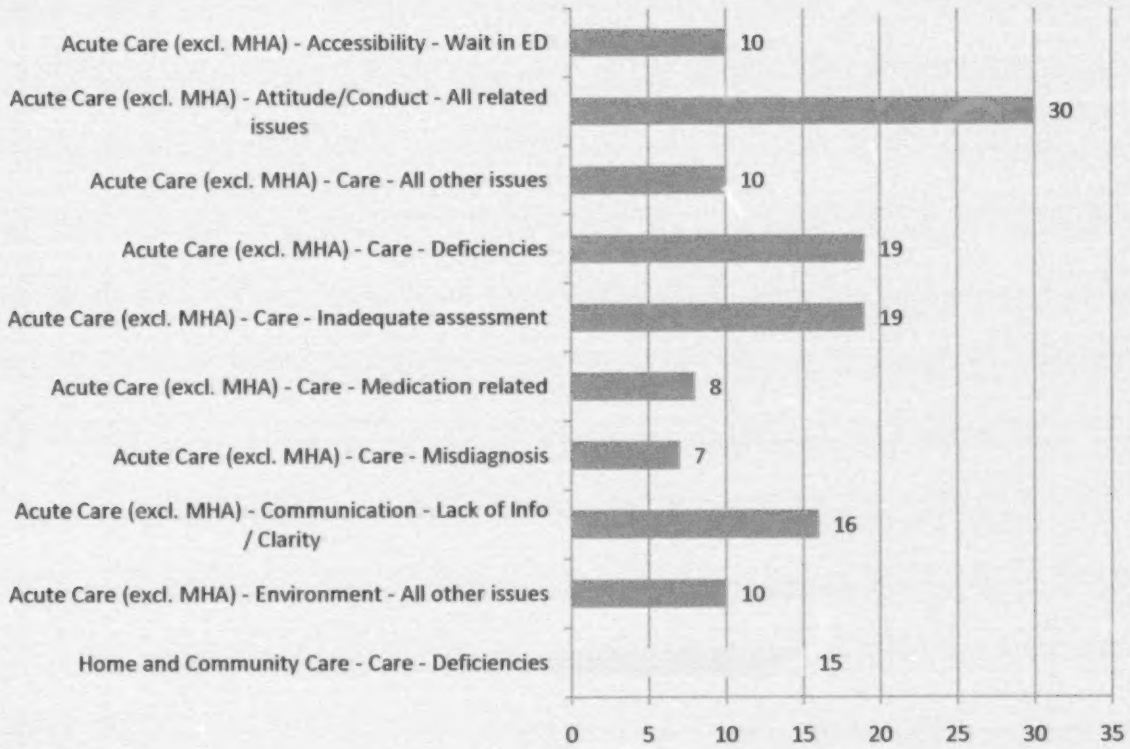

Acute Care (excl. MHA) - Accessibility - Wait in ED
26
Acute Care (excl. MHA) - Accessibility - Wait time for surg. / proc.
44
Acute Care (excl. MHA) - Attitude/Conduct - All related issues
82
Acute Care (excl. MHA) - Care - All other issues
62
Acute Care (excl. MHA) - Care - Deficiencies
72
Acute Care (excl. MHA) - Care - Medication related
24
Acute Care (excl. MHA) - Communication - All other issues
47
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
61
Acute Care (excl. MHA) - Environment - Housekeeping / Cleanliness
33
Acute Care (excl. MHA) - Financial - Billing
26
0 10 20 30 40 50 60 70 80 90

Northern Health Authority (NHA)

PCQO Volume, NHA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	23	13	13	15	**64**
Care Quality Complaints	27	42	57	62	**188**
Inquiries	4	2	2	9	**17**
Total Volume	54	57	72	86	**269**

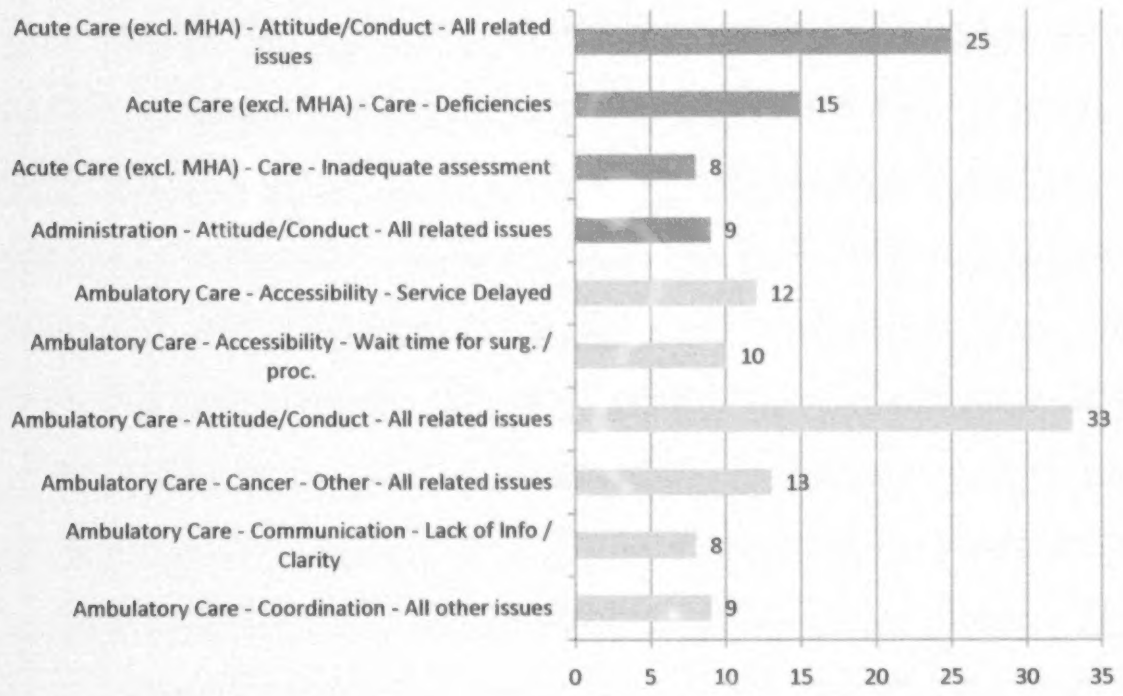
PCQO Top 10 Issues, NHA, 2009/10


Acute Care (excl. MHA) - Accessibility - Wait in ED
10
Acute Care (excl. MHA) - Attitude/Conduct - All related issues
30
Acute Care (excl. MHA) - Care - All other issues
10
Acute Care (excl. MHA) - Care - Deficiencies
19
Acute Care (excl. MHA) - Care - Inadequate assessment
19
Acute Care (excl. MHA) - Care - Medication related
8
Acute Care (excl. MHA) - Care - Misdiagnosis
7
Acute Care (excl. MHA) - Communication - Lack of Info / Clarity
16
Acute Care (excl. MHA) - Environment - All other issues
10
Home and Community Care - Care - Deficiencies
15
0
5
10
15
20
25
30
35

PCQO Volume, PHSA, 2009/10

	Apr-June 2009	July-Sept 2009	Oct-Dec 2009	Jan-Mar 2010	Total
External Complaints	3	13	7	2	**25**
Care Quality Complaints	63	37	36	42	**178**
Inquiries	90	49	76	97	**312**
Total Volume	156	99	119	141	**515**

PCQO Top 10 Issues, PHSA, 2009/10



Appendix C: Financial Report

The table below details the expenditures of the Boards in the fiscal year ending March 31, 2010.

Expenditures		Actual 2009/10 $
Board Members		
Board Member meeting fees		70 650
Board Member expenses		15 638
	Total	**86 288**
Board Support		
Board Support Personnel		520 273
Board Support Travel		15 020
Legal Expenses		5 667
Office Business and Info Systems		26 214
	Total	**567 174**
Total Expenditures		**653 462**

Further Information

Patient Care Quality Review Board Act

A copy of the *Patient Care Quality Review Board Act* may be obtained from www.patientcarequalityreviewboard.ca or by calling BC Laws toll-free at 1 866 236-5544.

Contact

For more information about the Patient Care Quality Review Boards, or to request a review, please contact:

Patient Care Quality Review Boards
PO Box 9643
Victoria BC V8W 9P1

Toll Free: 1 866 952-2448
Fax: 250 952-2428
Email: contact@patientcarequalityreviewboard.ca

Patient Care Quality Offices

To make a complaint regarding the quality of care that you or a loved one received, please contact the health authority Patient Care Quality Office in your region:

Vancouver Coastal Health Authority
855 West 12th Avenue, CP-380
Vancouver, B.C. V5Z 1M9
Telephone: 1-877-993-9199 (toll-free)
Fax: 604-875-5545
Email: pcqo@vch.ca
Website: www.vch.ca

Vancouver Island Health Authority
Royal Jubilee Hospital
Memorial Pavilion, Watson Wing, Rm 315
1952 Bay Street
Victoria, B.C. V8R 1J8
Telephone: 1-877-977-5797 (toll-free)
Fax: 250-370-8137
Email: patientcarequalityoffice@viha.ca
Website: www.viha.ca

Interior Health Authority
220-1815 Kirschner Road
Kelowna, B.C. V1Y 4N7
Telephone: 1-877-442-2001 (toll-free)
Fax: 250-870-4670
Email: patient.concerns@interiorhealth.ca
Website: www.interiorhealth.ca

Fraser Health Authority
32900 Marshall Road
Abbotsford, B.C. V2S 0C2
Telephone: 1-877-880-8823 (toll-free)
Fax: 604-854-2120
Email: pcqoffice@fraserhealth.ca
Website: www.fraserhealth.ca

Northern Health Authority
6th floor, 299 Victoria Street
Prince George, B.C. V2L 5B8
Telephone: 1-877-677-7715 (toll-free)
Fax: 250-565-2670
Email: patientcarequalityoffice@northernhealth.ca
Website: www.northernhealth.ca

Provincial Health Services Authority
(Includes provincial agencies and services such as BC Cancer Agency, BC Renal Agency, BC Transplant, and BC Women's and Children's Hospital)
4th Floor, Women's Health Centre, Room F404
4500 Oak Street
Vancouver, B.C. V6H 3N1
Telephone: 1-888-875-3256 (toll-free)
Fax: 604-875-3813
Email: pcqo@phsa.ca
Website: www.phsa.ca